

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **31021**

FILED OCT 5 1953

BIRTH NO. _____		REG. DIST. NO. <u>38</u>	PRIMARY REG. DIST. NO. <u>5122</u>	Registrar's No. <u>257</u>
1. PLACE OF DEATH a. COUNTY Boone County		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Boone		
b. CITY OR TOWN Hallsville Rocky Fork		c. CITY OR TOWN Hallsville Rocky Fork <i>0100</i>		
d. FULL NAME OF HOSPITAL OR INSTITUTION. 2 1/2 miles S E Hallsville		d. STREET ADDRESS (If rural, give location) 2 1/2 miles S E Hallsville <i>0</i>		
3. NAME OF DECEASED (Type or Print) a. (First) James Samuel b. (Middle) Hollins c. (Last) Sexton		4. DATE OF DEATH (Month) Sept (Day) 29 (Year) 1953		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Dec 19, 1882	9. AGE (In years last birthday) 70 IF UNDER 1 YEAR Months 9 Days 9 IF UNDER 4 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (State or foreign country) Boone County Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Pleasant C. Sexton		13b. MOTHER'S MAIDEN NAME Sara Ralston	14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or date of service)		16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Miss Flossie Rouse ADDRESS Hallsville, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cardiac failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) 1) Chronic degenerative myocarditis 2) Vascular Arteriosclerosis Aorta DUE TO (c) Arterio Sclerosis Heart Vessels		INTERVAL BETWEEN ONSET AND DEATH 6 Hrs 12-5-52 12-8-53 ?
19a. DATE OF OPERATION L		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) X		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) X	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4200	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) X		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? X	
22. I hereby certify that I attended the deceased from 12-4-1953 to 9-29-53 , that I last saw the deceased alive on 9-9-1953 , and that death occurred at 7:30 m., from the causes and on the date stated above.				
23a. SIGNATURE H. J. O. Palmer (Degree or title)		23b. ADDRESS Missouri	23c. DATE SIGNED 9-30-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 1, 1953	24c. NAME OF CEMETERY OR CREMATORY Mt Zion Cem	24d. LOCATION (City, town, or county) (State) Boone Co Mo	
DATE REC'D BY LOCAL REG. Oct 2, 1953	REGISTRAR'S SIGNATURE Mrs R.E. Palmer	25. FUNERAL DIRECTOR'S SIGNATURE W. L. ...	ADDRESS ...	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No.

Signed

Bill J. Meadows

Signed.....
Student Embalmer

Licensed Embalmer No. *4876*

P. O. Address *Central, Missis.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.